92-663

Supreme Court, U.S.
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No. _____

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER 1992 TERM

BOARD OF TRUSTEES OF KNOX COUNTY (INDIANA) HOSPITAL, d/b/a GOOD SAMARITAN HOSPITAL,

Petitioner,

v.

LOUIS W. SULLIVAN, M.D., as Secretary of the Department of Health and Human Services,

Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

L. Richard Gohman
(Counsel of Record)
William S. Hall
William H. Thompson
N. Kent Smith
HALL, RENDER,
KILLIAN, HEATH
& LYMAN, P.C.
Suite 1100, Box 82064
One American Square
Indianapolis, IN 46282
(317) 633-4884

Attorneys for Petitioners

QUESTIONS PRESENTED

1. Whether the United States Court of Appeals for the Seventh Circuit erroneously interpreted 42 U.S.C. § 1395ww(d)(5)(C)(i) (1984) to exclude increased reimbursement to rural referral center hospitals having less than 500 beds?

2. Whether the United States Court of Appeals for the Seventh Circuit failed to follow accepted principles of statutory construction as established by the United States Supreme Court?

3. Whether the United States Court of Appeals for the Seventh Circuit erroneously reached the merits of the petitioner's claim without affording the petitioner the opportunity to develop a factual record?

PARTIES TO THE PROCEEDINGS BELOW AND CORPORATE DISCLOSURE STATEMENT

The appellant in the court below, Board of Trustees of Knox County (Indiana) Hospital, d/b/a Good Samaritan Hospital, is the petitioner herein, and all parties to the proceeding in the United States Court of Appeals for the Seventh Circuit appear in the caption of this case.

Petitioner, appellant below, states that it has no parent company or subsidiary companies to be listed pursuant to Supreme Court Rule 29.1 and has no shares issued to the public.

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BOARD OF TRUSTEES OF KNOX COUNTY (INDIANA) HOSPITAL, D/B/A GOOD SAMARITAN HOSPITAL,

Petitioner,

v.

LOUIS W. SULLIVAN, M.D., AS SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

Petitioner prays that a writ of *certiorari* issue to review the judgment of the United States Court of Appeals for the Seventh Circuit entered in Case No. 91-2265 on June 25, 1992.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Seventh Circuit, Case No. 91-2265, is as yet unreported and is appended hereto. (Appendix A1, hereinafter "App. A—"). The order and judgment of the district court are unreported and are appended hereto. (App. A12, A23). The opinion of the Court of Appeals concluded that the district court erred in its conclusion that the petitioner did not have standing and that the respondent's action was committed to his discretion as a matter of law, but affirmed the district court's judgment on the basis that the conduct of the respondent

was not arbitrary, capricious, or an abuse of discretion because it was consistent with the authorizing statute.

JURISDICTIONAL STATEMENT

The judgment of the Court of Appeals was entered on June 25, 1992. Petitioner timely filed a petition for rehearing which was denied by the Court of Appeals by order dated July 14, 1992. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

The relevant statutory provision in this case is a part of Title XVIII of the Social Security Act (commonly known as "Medicare"), as amended, and more particularly the Social Security Amendments of 1983, Pub.L. No. 98-21, 97 Stat. 165. The statutory provision and regulation involved in this case are 42 U.S.C. § 1395ww(d)(5)(C)(i) (1984) (App. A24) and 42 C.F.R. § 405.476(g), 49 Fed.Reg. 320 (January 3, 1984) (App. A24).

STATEMENT OF THE CASE

Petitioner initiated this action by filing a complaint in the district court for damages arising out of a Medicare reimbursement dispute with the respondent, Louis W. Sullivan, M.D., as the Secretary of the Department of Health and Human Services. Jurisdiction in the district court was predicated upon 42 U.S.C. § 1395oo(f)(1). The respondent answered the petitioner's complaint and filed a motion for judgment on the pleadings. On April 4, 1991, the district court entered its order and judgment in which the court dismissed the petitioner's action.

The petitioner appealed the district court's order and judgment to the Court of Appeals. The jurisdiction of the Court of Appeals was predicated upon 28 U.S.C. § 1291 as an appeal of a final decision of the district court. On June 25, 1992, the Court of Appeals issued its opinion affirming the judgment of the district court. The petitioner timely filed a petition for rehearing in the Court of Appeals which was denied by order dated July 14, 1992. (App. A21).

The pertinent facts of this dispute are as follows. The petitioner is an acute care, multispecialty hospital with 344 beds located in Vincennes, Indiana. (App. A2). For purposes of Medicare reimbursement, the petitioner is classified as a rural hospital. (App. A2).

From the enactment of the Medicare program to 1983, the federal government reimbursed eligible hospitals at the lesser of the "reasonable cost" of covered services to Medicare beneficiaries or the customary charges with respect to such services. 42 U.S.C. § 1395(f)(b)(1). In 1983, Congress changed the method of paying hospitals under the Medicare program. The reimbursement method was changed to a Prospective Payment System ("PPS"). Social Security Amendments of 1983, Pub.L. No. 98-21, § 601, 97 Stat. 65 (codified as amended at 42 U.S.C. § 1395ww(d)). PPS became effective for hospital cost years beginning on or after October 1, 1983. Under PPS, hospitals are reimbursed at standardized amounts based upon the discharge diagnosis of the Medicare patients. These standardized amounts are known as Diagnosis-Related Groups ("DRG"). 42 U.S.C. § 1395ww(d)(3)(E). The system requires that the Secretary establish separate standardized amounts for urban and rural areas for each DRG. 42 U.S.C. § 1395ww(d)(2)(G).

At the start of PPS, a part of the payment was based on a combination of the national DRG prospective payment rate and a hospital's specific rate. 42 U.S.C. § 1395ww(d)(1)(A)-(C). Hospitals were divided into two categories: urban hospitals and rural hospitals. 42 U.S.C. § 1395ww(d)(2)(D). Hospitals such as the petitioner, located in rural areas, received less reimbursement to account for assumed differences in hospital wage levels. However, recognizing that this system would disadvantage certain hospitals, the Secretary was directed by Congress to make certain exceptions and adjustments to the prospective payment rates for certain types of facilities which Congress felt would be disadvantaged by the new prospective payment system. 42 U.S.C. § 1395ww(d)(5)(C). Such facilities included "regional and national referral centers."

In its Medicare cost report for its 1984 cost year, the hospital claimed reimbursement as a referral center. The Secretary disallowed the hospital's claim for reimbursement as a referral center, thereby reducing its Medicare reimbursement in excess of $700,000. (App. A2). The respondent's disallowance of the petitioner's claim for referral center status was based upon a regulation

adopted by the respondent limiting payment adjustments as a referral center during 1984 to rural hospitals having 500 or more beds. 49 Fed.Reg. 234, 320 at § 405.476(g)(1) (January 3, 1984). It is the Secretary's construction of section 1395ww(d)(5)(C)(i) as expressed in the disputed regulation which forms the basis of the present dispute.

The petitioner's complaint filed in the district court alleged that the respondent's regulation violated the Medicare statute by limiting referral center adjustment in reimbursement to rural hospitals having 500 or more beds. Petitioner alleged that the respondent's refusal to provide for referral center adjustment for hospitals of less than 500 beds was arbitrary and capricious and a violation of the Medicare statute.

In granting the respondent's motion for judgment on the pleadings, the district court concluded (1) that the petitioner had failed to establish that the disputed regulation limiting referral center reimbursement to 500-bed rural hospitals was invalid and that having failed to do so, the petitioner lacked standing; and (2) that judicial review was not available to petitioner under 5 U.S.C. § 701(a)(2) since the challenged agency action was committed to agency discretion by law.

On appeal, the Seventh Circuit Court of Appeals held that the district court had erred in its conclusions that the petitioner lacked standing and that the challenged agency action was committed to agency discretion by law. However, the Court of Appeals, nevertheless, affirmed the district court's decision on the basis of its opinion that the disputed regulation was consistent with the authorizing statute.

REASONS FOR GRANTING THE WRIT

The issues raised in this case are of first impression in this Court and involve important considerations of statutory construction. In construing the concededly ambiguous statutory provision at issue in this case, the Court of Appeals contradicted in principle the holdings of this Court in *Barlow v. Collins*, 397 U.S. 159 (1970) and *Montello Salt Company v. Utah*, 221 U.S. 452 (1911). In addition, in its opinion the Court of Appeals erroneously undertook a consideration of the merits of the petitioner's claim without affording the petitioner any opportunity to develop a factual record. Thus,

the Court of Appeals decided the merits of the case in the abstract and denied the petitioner the opportunity to present any meaningful challenge to the disputed regulation.

1. The Seventh Circuit Court of Appeals erroneously found that "[T]he statute can easily be read, therefore, as applying only to urban hospitals and rural hospitals with over 500 beds." (App. A10). This finding is contradictory to the legislative history of the statute, as well as to the court's acceptance of the purpose of the statute, which is to rectify the fact that urban hospitals receive more reimbursement under PPS than those rural hospitals that have similar operating characteristics such as high case-mix indices, diverse geographical patient origins, and numerous multi-disciplinary medical education programs. To find that the statute applies only to urban hospitals and rural hospitals with over 500 beds effectively limits the class of referral centers to rural hospitals over 500 beds since there is no need for urban hospitals to seek such status inasmuch as urban hospitals are already reimbursed at the higher urban rates.

This finding totally ignores the first part of the statute which requires the Secretary to make payment adjustments "to take into account the special needs of regional and national referral centers." Regional and national referral centers must be construed to mean rural hospitals with certain special characteristics (e.g., high case-mix indices, diverse geographical patient origins, and numerous multi-disciplinary medical education programs) since urban hospitals do not need the payment adjustment. Thus, the statute is not limited only to rural hospitals of more than 500 beds but also includes other large rural hospitals of less than 500 beds with certain special operating characteristics such as those of the petitioner.

In reaching its conclusion, the Court of Appeals accepted the respondent's interpretation of the ambiguous statute rather than assume the responsibility of resolving the issue by judicial application of accepted canons of statutory construction. In so doing, the Court of Appeals acted contrary to this Court's decision in the case of *Barlow v. Collins*, 197 U.S. 159 (1970), and effectively granted the Secretary unfettered authority to determine the meaning of the ambiguous term "referral center." Further, the Secretary was allowed to delay the implementation of the statutorily mandated payment adjustment for rural hospitals of less than 500 beds which otherwise met the criteria of a referral center. This grant of unfet-

tered authority to a governmental agency demonstrates the need for the exercise by this Court of its power of supervision under Sup.Ct.R. 16.1.

In *Barlow v. Collins*, 397 U.S. 159 (1970), the enabling statute gave the Secretary of Agriculture broad authority to "prescribe such regulations as he may deem proper to carry out the provisions of this chapter." *Barlow*, 397 U.S. at 165. The issue in *Barlow* was the definition of the statutory term "making a crop." In our case, as acknowledged by the Seventh Circuit, the issue is the definition of a "referral center." (App. A6).

In *Barlow*, this Court vacated the judgments of the district and circuit courts and remanded the case to the district court for a hearing on the merits. This Court held that the statutory authority of the federal official to promulgate such regulations "as he may deem proper" did not give the agency the discretionary power to define "making a crop." This Court held:

> [S]ince the only or principal dispute relates to the meaning of the statutory term, the controversy must ultimately be resolved not on the basis of matters within the special competence of the Secretary, but by judicial application of canons of statutory construction.
> "The role of the courts should, in particular, be viewed hospitably where . . . the question sought to be reviewed does not significantly engage the agency's expertise. '[W]here the only or principal dispute relates to the meaning of the statutory term' . . . [the controversy] presents issues on which courts, and not [administrators] are relatively more expert."
>
> * * *
>
> Therefore, the permissive term "as he may deem proper" by itself, is not to be read as a congressional command which precludes a judicial determination of the correct application of the governing canons.

397 U.S. at 166 (quoting *Hardin v. Kentucky Utilities Co.*, 390 U.S. 1, 14 (1967) (Harlin, J., dissenting)).

The statute at issue in this case, 42 U.S.C. § 1395ww(d), was enacted by Congress for the purpose of providing exceptions and

adjustments to reimbursement for certain types of hospitals which would be disadvantaged under the new PPS system. Urban hospitals were, in general, paid more under this new system on the assumption that they have higher labor and other operating costs. Therefore, the statute instructed the respondent to make exceptions or adjustments for six types of hospitals that may be disadvantaged. One such class of hospital was identified at 42 U.S.C. § 1395ww(d)(5)(C)(i) (1984) as follows:

> The Secretary shall provide for such exceptions and adjustments to the payment amounts established under this subsection as the Secretary deems appropriate to take into account the special needs of regional and national referral centers. . . .

The parenthetical phrase "(including those hospitals of 500 or more beds located in rural areas)" was added in Committee by Senator Cochran. (App. A9).

The respondent adopted a regulation which limited referral center reimbursement for 1984 to rural hospitals of 500 beds or more. The Secretary claimed that the statutory language "as the Secretary deems appropriate" gave him the discretionary power to deny such exceptions or adjustments to other than 500-bed rural hospitals. This is after the Secretary had admitted that he did not have the expertise to define a referral center. 49 Fed.Reg. 234, 275 (January 3, 1984) (App. A11).

The Secretary further claimed in argument before the Seventh Circuit Court that he planned to study rural hospitals of less than 500 beds which had claimed referral center status. In so doing, the Secretary effectively delayed any payment adjustments for rural referral center hospitals of less than 500 beds in contradiction to the statutory mandate. Nevertheless, the Court of Appeals accepted this explanation and held that the disputed regulation was consistent with the statute. In so doing, the Court of Appeals shirked its judicial responsibility of interpreting an ambiguous statute by judicial application of canons of statutory construction. Taken to its logical end, such conclusion would allow an agency to effectively ignore a statutory mandate by promulgating a nonresponsive regulation on the basis that the agency needs to study the issue before complying with Congressional pronouncement.

The respondent totally excluded any adjustments in reimbursement for rural referral centers having less than 500 beds. He claimed that the statute empowered him to do so on two (2) grounds. First, he claimed that the statute committed this decision to agency discretion under 5 U.S.C. § 701(a)(2). (App. A6). The Court of Appeals disposed of that issue in favor of the petitioner. Second, the respondent claimed that he needed more time to gather data to formulate criteria for referral center hospitals since he could not define the term "referral center." The Court of Appeals concluded that such a delay was a rational approach.

Petitioner claimed that the statute mandated the respondent to act but gave him power to determine the *amount* of reimbursement for referral centers. Petitioner urged that it be given an opportunity to develop a factual record to show that it is qualified to be considered a referral center for 1984. The Court of Appeals did not consider this request as being particularly relevant. (App. A9). The Court of Appeals concluded that:

> The Secretary's decision to adopt a regulation that effectively excluded rural hospitals with less than 500 beds is therefore neither arbitrary nor capricious.

(App. A10).

Petitioner submits that this conclusion is in error inasmuch as it is based on respondent's interpretation of a concededly ambiguous statute and was reached by the court without the benefit of a factual record on the meaning of the term "referral center."

2. The respondent adopted the disputed regulation implementing the referral center provision for 1984 at 49 Fed.Reg. 320 at § 405.476(g) (January 3, 1984). (App. A3). However, the only provision for adjustment in payments to referral center hospitals to pay them urban rates was in § 405.476(g)(2), which limited such adjustment to those hospitals located in rural areas and having 500 or more beds. (App. A4). Thus, the respondent and the Court of Appeals erroneously viewed the language in parentheses starting with the word "including" to control and limit the meaning of the general language preceding it.

In construing statutory terms, the courts must be guided in part by the purpose for which Congress enacted the statutory provision at issue. *See, C.I.R. v. Engle*, 464 U.S. 206 (1984).

Congress recognized that the implementation of PPS may have a very profound impact upon certain hospitals designated as "regional and national referral centers." In the Congressional debate leading to the enactment of the prospective payment system, referral centers were characterized as hospitals rendering extraordinary medical and surgical care and having technological sophistication characterized by high case-mix indices, diverse geographic patient origin, and numerous multi-diciplinary medical education programs. 129 Cong.Rec. S 3224-26 (March 17, 1983). In enacting § 1395ww(d)(5)(C)(i), Congress specifically intended to benefit referral centers and eradicate the undue hardship which the prospective payment system would impose upon such hospitals. *Id.* The respondent and the Court of Appeals wholly ignored the remedial nature of the statutory provision and construed the term "including" contained in the statute in an unrealistically narrow fashion to exclude rural hospitals with less than 500 beds.

In *Montello Salt Company v. State of Utah*, 221 U.S. 452, (1911), this Court discussed possible constructions of the term "including" contained in a statute. The *Montello* Court noted that the term may be construed to mean an addition to the more general words which precede the term or " 'may merely specify particularly that which belongs to the genus.' " 221 U.S. at 464-65 (quoting *Hiller v. United States*, 45 C.C.A. 229, 106 Fed. 73, 74). The Court decided that "including" is a participle, is in the nature of an adjective, and is a modifier. Therefore, this Court held that the words following "including" were "to be contained in or comprise a part" of the lands described which preceded the word "including." 221 U.S. at 465. This Court has, therefore, held that the use of the term "including" in statutory provisions such as that now before the Court merely specifies a subset within a larger general class. The Court of Appeals, however, interpreted the term as, in essence, controlling and limiting the meaning of the more general terms which preceded "including" in the statutory formulation. Petitioner views this as an indirect way of construing the word "including" as though it had read "meaning." Then the relevant statute would have read "(meaning those hospitals of 500 or more beds located in rural areas)."

The Court of Appeals' confusion regarding the term "referral center" and its resulting misconstruction of the term "including" is best observed in its interpretation that referral centers may be

expected to be located in urban areas. (App. A10). As pointed out previously, hospitals located in urban areas are compensated at higher urban rates under the general provisions of the PPS. Such hospitals, therefore, do not require the exception mandated in the statutory provision at issue in this case. The Court of Appeals' formulation had the net effect of excluding all rural hospitals of less than 500 beds from compensation at higher rates irrespective of their operating characteristics.

3. The erroneous opinion of the Court of Appeals was grounded in part upon the fact that the petitioner has not had an opportunity to develop an evidentiary record before the district court.

The term "referral center" is not defined in 42 U.S.C. § 1395ww(d)(5)(C)(i). As such, the statute is silent on the issue presented in this case. Under these circumstances, the Court of Appeals noted that its inquiry was whether the regulation was " 'rational and consistent with the statute.' " (App. A10) (quoting *Sullivan v. Everhart*, 110 S.Ct. 960, 964 (1990)). The Court of Appeals concluded that the regulation was facially consistent with the statute and found that "[T]he statute can easily be read, therefore, as applying only to urban hospitals and rural hospitals with over 500 beds." (App. A10). However, petitioner submits that facial consistency does not necessarily establish that a regulation is rational and, therefore, reasonable. The determination of rationality depends upon many other factors and issues which the petitioner was never given an opportunity to develop before the district court.

The respondent attempted to justify his regulation defining rural referral centers on the primary basis that at the time he issued the regulation, he did not have the necessary data to comply with the statute as it related to rural referral centers having less than 500 beds. This argument, however, provides no support for the respondent's contentions that the regulation he did issue (in the absence of the necessary data) and his decision to limit adjustments to hospitals having more than 500 beds were rational.

Whether the respondent's definition of rural referral centers as expressed in the disputed regulation and his decision to limit reimbursement adjustments to hospitals of greater than 500 beds were rational (and, therefore, reasonable) turns upon a variety of issues which the petitioner was never given an opportunity to present to the Court. Therefore, the Court of Appeals erroneously undertook a

consideration of the merits of the petitioner's claim without benefit of an appropriate record addressing the meaning of the term "referral center."

The Court of Appeals determined that a factual record was not necessary to interpret what it conceded to be an ambiguous statute. It reached this conclusion after first acknowledging that, in some circumstances, the development of facts should be allowed in order to allow a meaningful challenge to a regulation, but then finding that the facts that might have been presented by the hospital would not be particularly relevant to the meaning of the term "referral center." (App. A9). Instead the Court of Appeals relied upon the respondent's interpretation of the meaning of "referral center" without benefit of a record developed by the petitioner. Such a prospective determination of the relevancy of certain facts without such facts first being before the Court effectively precluded any meaningful challenge to the respondent's regulation.

CONCLUSION

WHEREFORE, for the foregoing reasons, petitioner prays that this Court issue a writ of *certiorari* to the Court of Appeals for the Seventh Circuit.

Respectfully submitted,

L. Richard Gohman
(Counsel of Record)
William S. Hall
William H. Thompson
N. Kent Smith
HALL, RENDER,
KILLIAN, HEATH
& LYMAN, P.C.
Suite 1100, Box 82064
One American Square
Indianapolis, IN 46282
(317) 633-4884

Attorneys for Petitioner

APPENDIX

In the

United States Court of Appeals

For the Seventh Circuit

No. 91-2265

BOARD OF TRUSTEES OF KNOX COUNTY (INDIANA) HOSPITAL d/b/a GOOD SAMARITAN HOSPITAL,

Plaintiff-Appellant,

v.

LOUIS W. SULLIVAN, in his capacity as Secretary of the Department of Health and Human Services,

Defendant-Appellee.

Appeal from the United States District Court
for the Southern District of Indiana, Terre Haute Division.
No. TH 90-186-C—**Larry J. McKinney**, *Judge.*

ARGUED JANUARY 13, 1992—DECIDED JUNE 25, 1992

Before CUMMINGS, CUDAHY, and POSNER, *Circuit Judges.*

CUMMINGS, *Circuit Judge.* Knox County Hospital seeks review of the Secretary's denial of the Hospital's Medicare reimbursement adjustment for fiscal year 1984. The Hospital claims that it should have been classified as a rural referral center in 1984 under 42 U.S.C. § 1395ww(d)(5)(C), and is therefore entitled to a higher reimbursement rate for its treatment of Medicare patients in that year.[1] Conceding that it does not meet in the regulatory definition of a rural referral center in effect in 1984, the Hospital complains that the regulatory definition was contrary to its implementing statute and otherwise arbitrary and capricious. The district court ruled on the pleadings that the Hospital had no standing, or alternatively that the agency's action was committed to its discretion by law and therefore judicial review was unavailable under 5 U.S.C. § 701(a)(2). We affirm, but on the ground that the

[1]Because of amendments to both the relevant statute and regulation, Knox Hospital has been classified since 1984 as a rural referral center and therefore has received more generous Medicare payments. This case involves the denial of a reimbursement adjustment for fiscal year 1984 only.

regulation in question was consistent with the statute and was not arbitrary or capricious.

I.

The facts are not disputed in this case. The Hospital is a full-service, acute-care hospital with 344 beds located in Vincennes, Indiana. It requested reimbursement as a rural referral center in its 1984 cost reported filed with Blue Cross and Blue Shield of Indiana, the fiscal intermediary appointed by the defendant pursuant to 42 U.S.C. § 1395h to help process Medicare claims. This request was denied. Under the procedures set forth in 42 U.S.C. § 1395oo, the Hospital appealed to the Provider Reimbursement Review Board, which also denied reimbursement as a rural referal center. It then sought judicial review pursuant to 42 U.S.C. § 1395oo(f)(1).

The Hospital claimed in district court that the Secretary's referral center regulation at 49 Fed. Reg. 320 (1984) violated the Medicare statute by denying the Hospital reimbursement as a rural referral center for its 1984 cost year. The rule was allegedly arbitrary and capricious. The Hospital also claimed that the denial of a reimbursement adjustment for the 1984 cost year deprived it of property without due process of law in violation of the Fifth Amendment.[2] Among other relief, the Hospital requested a judgment against the defendant in the amount of $711,426.00.

The district court entered judgment on the pleadings in favor of the defendant pursuant to Fed. R. Civ. P. Rule 12(c). The court first concluded that since the Hospital failed to establish that the definition of a rural referral center in the regulation was invalid, it lacked standing to bring suit because it failed to meet this definition. Alternatively, the district court held that judicial review was not proper under 5 U.S.C. § 701(a)(2) because the agency action here was committed to agency discretion.

II.

We can quickly dispose of any contention that the Hospital lacks Article III standing in this case. The Hospital's claim that it

[2]The Hospital does not pursue its Fifth Amendment claim on appeal.

was entitled to reimbursement under the Medicare statute without a doubt presents an injury traceable to the defendant that a favorable decision by the district court would remedy. Article III's requirement that federal courts adjudicate only live cases or controversies is therefore met. *Love Church v. City of Evanston*, 896 F.2d 1082, 1084-1085 (7th Cir. 1990), certiorari denied, 111 S. Ct. 252. The district court's confusion over the standing issue was a result of a somewhat unusual regulatory structure in effect during 1984, a topic to which we now turn.

In the Social Security Amendments of 1983, Pub. L. No. 98-21, 97 Stat. 165, Congress implemented a new method for reimbursing hospitals participating in Medicare known as the Prospective Payment System ("PPS"). Discarding a system based on reasonable costs of actual services performed. Congress decided that hospitals should be reimbursed according to a pre-set rate for various "diagnosis-related groups" ("DRGs"). See generally 42 U.S.C. § 1395ww(d). The PPS tracks cost data (used to calculate the DRG pre-set rates) separately for urban and rural hospitals; therefore, urban hospitals are generally speaking entitled to more reimbursements because of their greater costs. 42 U.S.C. § 1395ww(d)(2)(D). Recognizing that certain hospitals might be entitled to different treatment, Congress authorized several exceptions to the general payment scheme, including the followng statutory provision regarding referral centers in effect in 1984:

> The Secretary shall provide for such exceptions and adjustments to the payment amounts established under this subsection as the Secretary deems appropriate to take into account the special needs of regional and national referral centers (including those hospitals of 500 or more beds located in rural areas)* * *.

42 U.S.C. § 1395ww(d)(5)(C)(i) (1984).

The following regulation (in effect for fiscal year 1984) implemented the referral center exception:

> (g) *Referral centers.*
>
> (1) *Criteria.* HCFA [a Health and Human Services ("HHS") agency] will consider a hospital's request for a referral center

adjustment to the hospital's prospective payment rates only if the hospital is an acute care hospital that has a provider agreement under Part 489 of this chapter to participate in Medicare as a hospital; and

(i) Is located in a rural area (as defined in § 405.473(b)(6)) and has 500 or more beds available for use; or

(ii) Has an inpatient population such that at least 50 percent of its Medicare patients are referred from other hospitals or from physicians not on the staff of the hospital. In addition, at least 60 percent of the hospital's Medicare patients must live more than 25 miles from the hospital, and at least 60 percent of all services that the hospital furnishes to Medicare beneficiaries must be furnished to beneficiaries who live more than 25 miles from the hospital.

(2) *Payments to rural referral centers with 500 or more beds.* A hospital that meets the criteria of paragraph (g)(1)(i) of this section will be paid prospective payments per discharge based on the applicable urban payment rates as determined in accordance with § 405.473(b)(10) or (c)(6), as adjusted by the hospital's area wage index.

49 Fed. Reg. 320 (1984), 42 C.F.R. § 405.476(g).[3]

Under the regulation, a hospital conceivably could be classified as a referral center under either subsection (i) or (ii). However, a hospital would be entitled to urban payment rates only if it qualified under subsection (i) as a rural referral center with over 500 beds. All urban referral centers, as well as rural referral centers with less than 500 beds, would not be entitled to any different Medicare reimbursements under the 1984 regulation. Hence the district court's confusion over standing—the Hospital apparently spent some time attacking the specific requirements of subsection (ii) as unreasonable, but even if the requirements were different, the court reasoned, under section (2) the Hospital would not be entitled to urban payment rates because it had less than 500 beds. It is apparent, however, that the Hospital has standing to argue that the regulation itself is arbitrary or capricious.

[3]See 42 C.F.R. § 412.96 for the current version of this regulation.

Admittedly, the regulation seems somewhat odd. What, one might wonder, is the purpose for subsection (ii), since any hospital meeting the criteria established there is not entitled to any different treatment? It seems that the Secretary was interested in gathering data, since hospitals attempting to be classified under subsection (ii) were asked to submit cost data so that the Secretary could promulgate a more informed regulation. See 49 Fed. Reg. 276. As noted below, the legislative history suggests that Congress wanted the Secretary to take this investigatory approach.

III.

The Secretary contends that the Hospital is not entitled to challenge its 1984 referral center regulations in court because such matters are "committed to agency discretion by law" under Section 701(a)(2) of the Administrative Procedure Act (5 U.S.C. § 701(a)(2)). This Section where applicable trumps the general assumption that final agency actions are reviewable by courts under Section 702 of the APA ("A person suffering legal wrong because of agency action, or adversely affected or aggrieved by agency action * * * is entitled to judicial review thereof."). Section 701(a)(2) is a very narrow exception. *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 410.

The Supreme Court discussed Section 701(a)(2) in detail in *Heckler v. Chaney*, 470 U.S. 821, 828-829:

> On its face, the section does not obviously lend itself to any particular construction: indeed, one might wonder what difference exists between § (a)(1) [providing for no judicial review when "statutes preclude judicial review"] and § (a)(2). The former section seems easy in application; it requires construction of the substantive statute involved to determine whether Congress intended to preclude judicial review of certain decisions. * * * But one could read the language "committed to agency discretion *by law*" in § (a)(2) to require a similar inquiry. In addition, commentators have pointed out that construction of § (a)(2) is further complicated by the tension between a literal reading of § (a)(2), which exempts from judicial review those decisions committed to agency "discretion," and the primary scope of review prescribed by § 706(2)(A)—

> whether the agency's action was "arbitrary, capricious, or an *abuse of discretion*." How is it, they ask, that an action committed to agency discretion can be unreviewable and yet courts still can review agency actions for abuse of that discretion?

The Court attempted to resolve these puzzles by formulating the following standard: "[E]ven where Congress has not affirmatively precluded review, review is not to be had if the statute is drawn so that a court would have no meaningful standard against which to judge the agency's exercise of discretion." *Id.* at 830. The Court concluded that there was no meaningful standard against which to judge the FDA's decision not to begin an enforcement action relating to the safety of drugs used for lethal injection by states implementing the death penalty.

Section 701(a)(2) "requires careful examination of the statute on which the claim of agency illegality is based." *Webster v. Doe*, 486 U.S. 592, 600. In deciding whether Congress intended to commit a particular action to an agency's discretion as a matter of law, we must consider the statutory language, the structure of the statute, any relevant legislative history if the statute is ambiguous, and the nature of the agency action being challenged. *Singh v. Moyer*, 867 F.2d 1035, 1038 (7th Cir. 1989). The gist of the Hospital's challenge is that the regulation is contrary to criteria set forth in the statute's legislative history. Our analysis of the factors listed above leads to the conclusion that judicial review is proper in this case.

An important reason for deciding that judicial review is appropriate is the nature of the agency action being challenged here. Whether a regulation is contrary to its authorizing statute is almost always a legal question appropriate for judicial review. This case is similar to *Barlow v. Collins*, 397 U.S. 159, where the Secretary's authorization to enact regulations "as he may deem proper to carry out the provisions" of the statute was found not to commit to his discretion the definition of "making a crop." *Id.* at 166. Where the principal dispute relates to the meaning of a statutory term, the controvery is ultimately resolved by application of canons of statutory construction *Id.* Here the primary dispute relates to the meaning of the statutory phrase "regional and national referral center." Agency actions are more likely to be committed to agency discretion when they involve factual disputes, particularly those of a politically sensitive nature. *E.g.*, *Webster v. Doe*, 486 U.S. 592 (decision by the Director of the CIA to fire an employee within his

discretion); *Specter v. Garrett*, 1992 U.S. App. LEXIS 6969, No. 91-1932 (3rd Cir. April 17, 1992) (Department of Defense's substantive recommendation of military bases to close not reviewable, but allege failure to follow procedures mandated by statute is reviewable); *Scalise v. Thornburgh*, 891 F.2d 640 (7th Cir. 1989) (decision to deny international prison transfer committed to agency discretion), certiorari denied, 494 U.S. 1083.

The real dispute here is the nature of the obligation created by the following words of Section 1395ww(d)(5)(C): "The Secretary *shall provide* for such exceptions and adjustments * * * *as the Secretary deems appropriate* to take into account the special needs of regional and national referral centers * * *." (emphasis added). In a battle of underlining, the Hospital emphasizes the phrase "shall provide," whereas the Secretary emphasizes the phrase "as the Secretary deems appropriate." The Hospital, then, sees the statute as imposing a mandatory duty on the Secretary, with any discretion on the Secretary's part limited to the *amount* of adjustment to give to referral centers. The Secretary views the statute as no more than a grant of authority that he may or may not use in his discretion.

The statute is unfortunately ambiguous on this score. After the secretary has decided to implement a regulation, however, it is difficult to conclude that the regulation cannot be reviewed for its consistency with the statute, especially since the Secretary conceded at oral argument that the phrase "special needs of regional and national referral centers" in the statute provides a standard for a court to apply. Congress easily could have drafted a statute that more clearly placed the content of a regulation in the Secretary's discretion. For example, in *Greater New York Hospital Association v. Mathews*, 536 F.2d 494 (2d Cir. 1976), the statute clearly left the matter of timing of certain Medicare payments in the discretion of the Secretary, as long as payments were made at least once a month—"the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly)." A court faced with that type of statutory language could freely ignore arguments that a certain payment scheme that provided for at least monthly payments was yet unreasonable for some reason. On the other hand, it is less obvious that a court can ignore an argument that a regulation totally contravenes "the special needs of regional and national referral centers."

The structure of the Medicare Act also supports a conclusion that the Secretary's referral center regulation is reviewable. An important consideration when examining the structure of a statute for this purpose is whether the statute exudes deference to the implementing agency. The Supreme Court in *Webster* noted that various provisions of the National Security Act exhibit "extraordinary deference" to the Director. 486 U.S. at 600-601. Similarly, this Court in *Arnow v. United States Nuclear Regulatory Commission*, 868 F.2d 223 (1989), certiorari denied, 493 U.S. 813, noted that the "entire scheme" of the Atomic Energy Act "vests very wide discretion in the agency." *Id.* at 233. See also *Federal Deposit Ins. Corp. v. Bank of Coushatta*, 930 F.2d 1122 (5th Cir. 1991) (numerous provisions of International Lending Supervision Act as well as its legislative history indicates that FDIC's decision to issue a capital directive is entitled to substantial deference and is therefore committed to agency discretion by law), certiorari denied, 112 S. Ct. 170. Unlike the statutory schemes noted above, the Medicare Act does not give unusual deference to the Secretary. It is instead a detailed and meticulous statute that imposes a number of mandatory duties upon the HHS. See *Loyola University of Chicago v. Bowen*, 905 F.2d 1061, 1067 (7th Cir. 1990).

We note also that Section 1395oo(g) lists certain findings that are not reviewable "by any court," which suggests that all other findings are reviewable. 42 U.S.C. § 1395oo(g). In addition, referral centers are but one of several types of hospitals that are authorized to receive certain exemptions and adjustments to the PPS. Other hospitals receiving exemptions include sole community hospitals, hospitals extensively involved in cancer treatment and research, hospitals with disproportionate numbers of low-income or Medicare beneficiaries or both, and hospitals in Alaska and Hawaii. 42 U.S.C. § 1395ww(d)(5)(D)-(H). Finally, Congress granted the Secretary a catch-all exception that authorized him to make other exceptions and adjustments as he deems appropriate. 42 U.S.C. § 1395ww(d)(5)(I). This section is clearly discretionary, and implies that the other sections are not totally discretionary.[4]

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[4]The Hospital places much emphasis upon the referral center provision's legislative history, indicating that it provides a meaningful standard upon which to base judicial review. There is in fact little in the scant legislative history to support this conclusion. See 129 Cong. Rec. 5897-5899 (March 17, 1983). Senator Bentsen introduced the provision, noting that "[w]e have a number of hospitals that are

(Footnote continued on following page)

IV.

We then proceed to the merits, whether the Secretary's adoption of the referral center regulation is arbitrary, capricious, an abuse of discretion, or contrary to the underlying statute under Section 706 of the APA. The Hospital claims that this Court should not reach this question, noting that the court below did not rely upon it and that it needs to develop a factual record. The district court's discussion of the standing issue, however, includes a finding that "the Secretary's definition of referral centers is both rational and consistent with the Act" (Appellant's App. at 10). Furthermore, a factual record is not necessary to resolve what is largely a legal issue raised by the Hospital. Even if in some circumstances development of facts should be allowed in order to allow a meaningful challenge to a regulation, the facts that the Hospital believes it can show do not strike us as being particularly relevant.

The scope of review under the arbitrary and capricious standard is narrow, and this Court is not permitted to supplant its own judgment for that of the agency. *St. James Hosp. v. Heckler*, 760 F.2d 1460, 1465 (7th Cir. 1985), certiorari denied, 474 U.S. 902. Because the statute itself does not define a "referral center," our

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[4] *continued*

national and regional referral centers where we can send patients who require an intensity of resources beyond the capabilities of general community hospitals." *Id.* at 5898. These hospitals are "characterized by high case mix indices, diverse geographical patient origin, and numerous multidisciplinary medical education programs." *Id.* Senator Dole added:

> Regional and national referral centers may be quite different from other hospitals. * * * We do not have the data, nor can we perform at this time the analysis needed, to verify that such centers require $10, $100, or $1,000 more per case than other hospitals. * * * [S]ome analysis is necessary and if the results so indicate, adjustments must be made for the special needs of these hospitals. * * * The amendment * * * directs the Secretary to examine the experience of these hospitals carefully and to make the necessary adjustments to their reimbursement to account for their special circumstances.

Id. Senator Cochran then offered the amendment adding the parenthetical language "including those hospitals of 500 or more beds located in rural areas." *Id.* The Senator stated that his amendment "will provide for the Secretary to permit payment to these large rural hospitals at the same rate as the urban hosptials if it is found that the cost they incur in delivery of health care justified that level of payment." *Id.* at 5899. In sum, the legislative history indicates that the Secretary was "directed" only to study the situation and was given considerable discretion when and how to treat referral centers.

inquiry is whether the regulation is "rational and consistent with the statute." *Sullivan v. Everhart*, 110 S. Ct. 960, 964 (quoting *NLRB v. United Food & Commercial Workers*, 484 U.S. 112). Congress expressed concern for "regional and national referral centers." These words imply large facilities, ones "regional" and "national" in scope. Indeed, one might expect such hospitals to be located in urban areas. The sponsor of the amendment, Senator Bentsen of Texas, in his remarks on the Senate floor cited Houston hospitals as examples of facilities that might be entitled to the exception. Perhaps fearful that the exception would be limited to urban hospitals, Senator Cochran of Mississippi added the parenthetical "including rural hospitals with over 500 beds," citing a hospital in his state he thought also might be entitled to the exception. The statute can easily be read, therefore, as applying only to urban hospitals and rural hospitals with over 500 beds.

The Secretary's decision to adopt a regulation that effectively excluded rural hospitals with less than 500 beds is therefore neither arbitrary nor capricious. The Hospital's reliance on several statements in the Congressional Record is misplaced. These remarks were brief, exceedingly general and only purported to describe what a particular Senator thought the characteristics of a referral center might look like—"technologically sophisticated," "high case mix indices," "diverse geographical patient origin," "numerous multidisciplinary medical education programs," and "ability to care for the sickest, most resource-intensive patients." Nothing indicates that the Senators thought these vague criteria had to be adopted in some fashion by the Secretary.

More importantly, as noted above, the thrust of the remarks in the Congressional record is that the Secretary was to gather data about these hospitals in order to formulate more meaningful criteria. This is exactly the approach the Secretary took:

> We stated in the interim final rule that during the second six months of the first transition year, we would analyze all data submitted during the first six months of the first transition year by hospitals seeking referral center status to determine which payment adjustments may be appropriate beginning with the second transition year.

> Since there is no generally accepted definition of referral centers, it is not possible at this time to determine which payment adjustments are appropriate.

49 Fed. Reg. 276. The decision to grant immediate adjustments to rural hospitals with over 500 beds was not discussed in detail in the regulatory comments, but is reasonable given the explicit mention of these types of hospitals in the statute.

The Hospital claims it should be given the opportunity to show that no hospital in the country could qualify for subsection (ii) of the regulation, which defines a referral center based on the percentage of referrals it receives and the number of patients outside a local geographical area it treats. Even if this were true, it would hardly matter, since hospitals meeting those criteria would not have been treated differently anyway because adjustments were limited in 1984 for rural hospitals with over 500 beds. The challenged requirements are certainly facially consistent with the statute, and indeed were relaxed in response to criticism of the original proposed rule. See 49 Fed. Reg. 275. The Secretary made it clear that he wanted information from all hospitals seeking referral center status so that he could make a more informed decision the next year. This approach is reasonable and consistent with the statute.

V.

Although the district court erred in concluding that the Hospital did not have standing and that the Secretary's action was committed to his discretion as a matter of law, we affirm that court's judgement on the basis that the regulation being challenged was not arbitrary, capricious or an abuse of discretion because it was consistent with the authorizing statute.

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Clerk of the United States Court of Appeals for the Seventh Circuit

USCA A07XXXC-92-001—Midwest Law Printing Co., Inc., Chicago—6-25-92

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF INDIANA

TERRE HAUTE DIVISION

BOARD OF TRUSTEES OF KNOX COUNTY (INDIANA) HOSPITAL, d/b/a GOOD SAMARITAN HOSPITAL,	)	FILED APRIL 4, 1991
Plaintiff,	)	
vs.	)	**CAUSE NO. TH 90-186 C**
LOUIS W. SULLIVAN, M.D., as Secretary of the Department of Health and Human Services,	)	
Defendant.	)	

ORDER ON DEFENDANT'S MOTION FOR JUDGMENT ON THE PLEADINGS

This cause is before the Court on defendant's motion for judgment on the pleadings pursuant to Federal Rule of Civil Procedure 12(c). The issues raised have been briefed and are ready for resolution. For the reasons set forth, the Court finds that the plaintiff lacks standing to litigate the issues and GRANTS the defendant's motion.

I. PROCEDURAL AND FACTUAL BACKGROUND[1]

The plaintiff, the Board of Trustees of Knox County Hospital, d/b/a Good Samaritan Hospital (the "Hospital"), is a 340-bed general acute care county hospital located in Vincennes, Indiana. In October, 1990, the Hospital filed a complaint against the defendant, Louis W. Sullivan, M.D., as Secretary of the Department of Health and Human Services ("Secretary"), seeking increased reimbursement for services it rendered Medicare beneficiaries during 1984. The Hospital contends that the regulatory prerequisites promulgated by the Secretary for enhanced compensation are contrary to the language of the statute, and must be set aside.

Title XVIII of the Social Security Act ("Act" or "Medicare Act"), 42 U.S.C. § 1395 *et. seq.*, authorizes the Secretary to make payments for covered medical care provided primarily to eligible aged and disabled persons. Prior to 1983, the amount reimbursed for services rendered by a provider under the Act was based on the reasonable cost or customary charges for the services, whichever was lower. 42 U.S.C. § 1395 f(b). However, in the Social Security Amendments of 1983 ("1983 amendments"), Congress switched from a cost reimbursement system to a prospective reimbursement system and created the Prospective Payment System ("PPS").

Under the PPS, payments to hospitals are generally based upon prospectively determined payment rates that vary according to the type and category of hospital treatment rendered, regardless of the actual costs incurred by the provider. The statute contains a complex formula for calculating prospective payment rates. The Secretary first must calculate the average Medicare allowable costs per discharge for each hospital participating in the Medicare program. 42 U.S.C. § 1395 ww(d)(2)(A). These updated averages were standardized to remove the effects of indirect medical education costs, as well as variations in individual hospital wage levels and complexity of cases. The Secretary then computes separate averages of these standardized amounts for urban areas and rural areas. After all requisite adjustments, the Act requires the Secretary to establish separate standardized amounts for urban and rural areas

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[1]In ruling on a motion to dismiss or a motion for judgment on the pleadings, the Court must take the plaintiff's well-pleaded allegations as true. *Gomez v. Illinois State Board of Education*, 811 F.2d 1030, 1039 (7th Cir. 1987) (motion to dismiss). Additionally, the Court must view those allegations in the light most favorable to the plaintiff. *Id.*; Wright and Miller, *Federal Practice and Procedure* § 1386 (1990).

for each diagnosis related group. 42 U.S.C. § 1395 ww(d)(2)(G). Actual PPS payment rates for each hospital are then computed by adjusting these standardized amounts to account for the difference between wage levels in the geographic area of a particular hospital and the national average hospital wage level. 42 U.S.C. § 1395 ww(d)(2)(H).

The case at bar concerns a particular hospital's entitlement to obtain an adjustment to the payment rates calculated using the aforementioned method for services rendered in 1984. Congress provided for the possibility of adjustments to the standard rates. The relevant provision of the Act states:

> The Secretary shall provide for such exceptions and adjustments to the payment amounts established under this subsection as the Secretary deems appropriate to take into account the special needs of regional and national referral centers (including those hospitals of 500 or more beds located in rural areas).

42 U.S.C. § 1395 ww (d)(5)(C)(i).

The Secretary promulgated the following criteria to identify referral centers:

> (g) Referral Centers
>
> (1) Criteria. HCFA will consider a hospital's request for a referral center adjustment to the hospital's prospective payment rates only if the hospital is an acute care hospital that has a provider agreement . . . to participate in Medicare as a hospital; and
>
> (i) Is located in a rural area . . . and has 500 or more beds available for use; or
>
> (ii) Has an inpatient population such that at least 50 percent of its Medicare patients are referred from other hospitals or physicians not on the staff of the hospital. In addition, at least 60 percent of the hospital's Medicare patients must live more than 25 miles from the hospital, and at least 60 percent of all the services that the hospital furnishes to Medicare beneficiaries must be furnished to Medicare beneficiaries who live more than 25 miles from the hospital. (''subparagraph (ii)'').

49 Fed. Reg. 234, 320 § 405.476(g)(1) (January 3, 1984).

For the time period in question, the Secretary ruled that rural referral centers with 500 or more beds would be paid prospective payments per discharge based upon the rates applicable to urban hospitals, a much higher rate. The Secretary did not provide for any increase for rural hospitals qualifying as referral centers under § 405.476(g)(1)(ii). The plaintiff contends that not providing an increase in reimbursement for a rural hospital that would qualify as a referral center under § 405.476(g)(1)(ii) is contrary to the enabling statute.

The plaintiff Hospital is a provider of medical services under the Act. The Hospital is classified as a rural hospital, and sought increased reimbursement as a rural referral center for its 1984 costs year. It is not contended that the Hospital meets the 500-bed minimum under § 405.476(g)(1)(i). In its cost report for 1984, the Hospital contended that the Secretary was required to increase the reimbursement for all rural referral centers. The Indiana Medicare Fiscal Intermediary (Blue Cross and Blue Shield of Indiana) denied additional reimbursement for 1984, and issued a Notice of Program Reimbursement reflecting such denial. The plaintiff sought review before the Provider Reimbursement Review Board ("PRRB"). 42 U.S.C. § 1395 oo(a) and (b). On August 23, 1990, the PRRB determined that the Hospital's claim involved a question of law or regulations that it was without authority to decide. On October 19, 1990, the Hospital filed this action contending that it was unlawfully denied reimbursement as a rural referral center. The action before this Court is to be conducted in accordance with the requirements of the Administrative Procedure Act ("APA"). 5 U.S.C. § 701-06.

II. DISCUSSION

The Secretary supports his motion for judgment on the pleadings on two separate grounds. First, the Secretary contends that the Court lacks jurisdiction because the Secretary's decision to deny the Hospital additional reimbursement due to its size constituted an agency action committed to agency discretion and is precluded from judicial review. 5 U.S.C. § 701(a)(2). Second, the Secretary argues that the Hospital is without standing to even argue the issue of agency discretion because the Hospital does not qualify as a referral center under the Act and therefore was not harmed by the agency's exclusion of referral centers with less than 500 beds. Be-

cause the issue of standing is depositive, the Court will address this issue first.

A. STANDING

Under traditional standing analysis, Article III requires a party to show that he personally has suffered some actual or threatened injury, and that the injury fairly can be traced to the challenged action and is likely to be redressed by a favorable decision. *See generally Valley Forge Christian College v. Americans United for Separation of Church & State, Inc.*, 454 U.S. 464, 472 (1982); *Love Church v. City of Evanston*, 896 F.2d 1082, 1084-85 (7th Cir. 1990). The Secretary argues that the plaintiff lacks standing because it is not a referral center, and any increase in the compensation to referral centers ordered by the Court would not increase the compensation to the plaintiff. Thus, a favorable decision for the plaintiff would not redress the alleged injury.

As previously established, to be considered a referral center a rural hospital must:

> (i) [be] located in a rural area . . . and ha[ve] 500 or more beds available for use; or
>
> (ii) Ha[ve] an inpatient population such that at least 50 percent of its Medicare patients are referred from other hospitals or physicians not on the staff of the hospital. In addition, at least 60 percent of the hospital's Medicare patients must live more than 25 miles from the hospital, and at least 60 percent of all the services that the hospital furnishes to Medicare beneficiaries must be furnished to Medicare beneficiaries who live more than 25 miles from the hospital.

49 Fed. Reg. 234, 320 § 405.476(g)(1) (January 3, 1984).

The Hospital does not contend that it qualifies under either of the above criteria. Instead, the Hospital argues that subparagraph (ii) is meaningless because even if it did meet the subparagraph, the Secretary did not make a provision for any adjustment to hospitals satisfying this category. Additionally, the Hospital briefly argues that the regulation is totally unresponsive to the enabling statute and the intent of Congress.

The plaintiff has jumped to the end of the analysis without fully considering § 405.476(g)(1)(ii) and the doctrine of standing. The plaintiff states that "[t]he Secretary, by his Regulations, in ef-

fect, provides for rural referral center status only for those rural hospitals with more than 500 beds." Plaintiff's Response Brief p. 21. True, the Secretary has provided increased compensation only for rural referral centers with more than 500 beds. However, the Secretary granted referral center status to any size rural hospital if it meets certain criteria. The plaintiff chooses to attack the Secretary's decision to limit any increased compensation to referral centers with more than 500 beds without first fully establishing that the Secretary's definition of referral center is unlawful.

In its limited attack on subparagraph (ii), the Hospital argues that the regulation satisfies neither the statutory mandate of 42 U.S.C. § 1395 ww(d)(5)(C)(i) nor Congressional intent behind the statute.[2] The Congressional Committee did state as characteristics of referral centers availability of extraordinary medical and surgical care to the sickest and most resource intensive patient populations, an intensity of resources beyond the capabilities of general community hospitals, technological sophistication characterized by high case mix indices, diverse geographical patient origin and numerous multidisciplinary medical education programs and capability of offering diverse, highly specialized training in all areas of medical care. 129 Cong. Rec. 5898 (March 17, 1983). Plaintiff argues that subparagraph (ii) satisfies none of these factors. The Court disagrees.

In promulgating the rule, the Secretary chose two criteria. The first prerequisite considers the number of referrals. The Secretary concluded that the number of referrals would also be a measure of those hospitals that treat the sickest patients, presumably because it is those patients that will be transferred. Second, the criteria relating to the geographic diversity of the patient population were intended to ensure that the affected hospitals were regional and national referral centers as contemplated by the statute. 49 Fed. Reg. 234, 275 (January 3, 1984). The test of whether the agency's definition of a term used in the enabling act is unlawful is whether the definition is rational and consistent with the enabling statute, not whether the definition turns out to be prudent. *Sullivan v. Everhart*, 110 S. Ct. 960, 964 (1990). The Court finds that the Secretary's definition of referral centers is both rational and consistent with the Act. The Secretary's definition attempts to identify charac-

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[2]The primary inquiry is whether the definition of referral centers meets the enabling statute. The text of a statute, not the legislative history, is the law. *See Chrysler Corp. v. Brown*, 441 U.S. 281, 311 (1979).

teristics of a rural referral center, as set out in the legislative history, and yet remove subjectivity from the determination. This is a difficult task and the Court cannot say that choices made by the Secretary are inconsistent with the Act.

The plaintiff also points out that no rural hospitals applied for relief under subparagraph (ii) in 1984, and that the Secretary later amended this subparagraph. Both of these facts are no aid to the Hospital. The test to be applied is one of rationality with the Act, not the merits of the action. The above two facts address the merits of the Secretary's action, not its consistency with the Act and legislative history.

In summary, even assuming *arguendo* that the Secretary's decision to restrict increased reimbursement to rural referral centers with more than 500 beds is contrary to the enabling statute, the plaintiff has not established that a favorable decision will redress its alleged injury. The plaintiff does not meet the definition of a rural referral center. For the plaintiff to be entitled to an increase in reimbursement, it must establish that the definition of a referral center was unlawful. The plaintiff has failed to do this, and thus lacks standing to bring suit.

B. AGENCY DISCRETION

Even if the Hospital has standing to bring the instant action, judicial review is proper only if the decision of the Secretary was not an agency action committed to agency discretion. 5 U.S.C. § 701(a)(2). The issue to be addressed in this section is whether the Secretary's refusal to increase the compensation for rural referral centers with less than 500 beds constituted a discretionary act and thus precludes judicial review.

The relevant provision of the enabling act states:

> The Secretary shall provide for such exceptions and adjustments to the payment amounts established under this subsection as the Secretary deems appropriate to take into account the special needs of regional and national referral centers (including those hospitals of 500 or more beds located in rural areas).

42 U.S.C. § 1395 ww (d)(5)(C)(i).

The plaintiff reads this statute to require exceptions and to allow the Secretary reasonable discretion as to only the amount of the

adjustment. The Secretary reads this statute to allow exceptions and adjustments as he deems appropriate. The question is whether the language of the Act is permissive or mandatory.

The first issue is the standard to be applied. The Hospital contends that the exceptions to judicial review listed in § 701(a) of the APA must be narrowly construed and may be invoked by the opponent to judicial review only upon a showing of clear and convincing evidence of legislative intent to restrict access to the courts. The plaintiff misreads the case law. In *Citizens To Preserve Overton Park v. Volpe*, 401 U.S. 402, 410 (1971), and *Abbott Laboratories v. Gardner*, 387 U.S. 136, 141 (1967), the Supreme Court required clear and convincing evidence of Congressional intent to preclude judicial review under § 701(a)(1) of the APA. Section 701(a)(1) provides that the APA is inapplicable to the extent that the statute expressly precludes judicial review. To apply the same standard to § 701(a)(2) would effectively make the provision useless because clear evidence of agency discretion would also satisfy § 701(a)(1). *Heckler v. Chaney*, 470 U.S. 821, 829-30 (1985). Section (a)(2) applies where Congress has not affirmatively precluded review, thus the clear and convincing standard is not applicable. *Id.*

Now turning to the question of whether the language of the Act is permissive or mandatory, the Court finds that the language is permissive. The legislative history indicates that Congress specifically considered imposing a mandatory duty upon the Secretary, and reject that approach in favor of a permissive approach.

> We had hoped to be able to get the committee to go along with a simple amendment that would treat these large rural area hospitals, with 500 beds or more in their facility, as if they were urban hospitals. I still think that is the simplest way to do it — but because of objections from the Department and the committee, we are offering an alternative. This will provide for the Secretary to permit payment to these large rural hospitals at the same rate as the urban hospitals if it is found that the cost they incur in delivery of health care justified that level of payment.

129 Cong. Reg. 5899 (March 17, 1983) (Senator Cochran). As stated by Senator Dole, the Secretary is to make an adjustment if it makes sense given the particular circumstances after a close look at the details. *Id.* The Secretary is to undertake this analysis and make

the determination. Thus, the legislative history indicates that the Act was meant to defer judgment to the Secretary.[3]

Additionally, similar language to that in the enabling statute has been held to be discretionary. *See Webster v. Doe*, 486 U.S. 592 (1988) ("[W]henever [the Director] shall deem such termination necessary" held to give discretion to the Director and precluded judicial review). The Act states that the Secretary shall take action as he deems appropriate. This is a clear example of an action committed to the discretion of an agency and under § 701 (a)(2) this Court may not review the agency action.

III. CONCLUSION

In summary, the plaintiff lacks standing to bring suit because, even assuming *arguendo* that the Secretary's decision to restrict increased reimbursement to referral centers with more than 500 beds is contrary to the enabling statute, the plaintiff has not established that a favorable decision will redress its alleged injury as it does not meet the agency's lawful definition of a rural referral center. Also, § 701(a)(2) of the APA bars judicial review of the Secretary's decision because the determination was committed to agency discretion by law. The function of this Court is not to examine the subjective fairness of the Secretary's actions, but to assess their legality. The court GRANTS the defendant's motion for judgment on the pleadings.

IT IS SO ORDERED this 4th day of April, 1991.

LARRY J. McKINNEY, JUDGE
United States District Court
Southern District of Indiana

[3]The legislative history indicates that Congress was concerned with only a few very large rural hospitals when it granted the Secretary the power to treat rural referral centers as urban hospitals. The record is devoid of a concern for small rural hospitals. Based on the legislative history, the Secretary not only had the discretion to decide if a rural hospital was entitled to an increase in compensation, the Secretary correctly focused on large rural hospitals.

United States Court of Appeals

For the Seventh Circuit
Chicago, Illinois 60604

July 14, 1992.

Before

Hon. WALTER J. CUMMINGS, Circuit Judge
Hon. RICHARD D. CUDAHY, Circuit Judge
Hon. RICHARD A. POSNER, Circuit Judge

BOARD OF TRUSTEES OF KNOX COUNTY (INDIANA) HOSPITAL, d/b/a GOOD SAMARITAN HOSPITAL, Plaintiff-Appellant,	Appeal from the United States District Court for the Southern District of Indiana, Terre Haute Division. No. TH 90-186-C
No. 91-2265 **vs.** LOUIS W. SULLIVAN, in his capacity as Secretary of the Department of Health and Human Services, Defendant-Appellee.	Larry J. McKinney, Judge.

ORDER

The opinion issued June 25, 1992, is amended by replacing the last two sentences of the first paragraph in Section I with the following sentence:

> Under the procedures set forth in 42 U.S.C. § 1395oo, the Hospital appealed to the Provider Reimbursement Review Board, which granted the Hospital's request for expedited judicial review pursuant to 42 U.S.C. § 1395oo(f)(1).

In all other respects the petition for rehearing is DENIED.

United States Court of Appeals

For the Seventh Circuit
Chicago, Illinois 60604

JUDGMENT — WITH ORAL ARGUMENT

Date: June 25, 1992

BEFORE: **Honorable** Walter J. Cummings, Circuit Judge
Honorable Richard D. Cudahy, Circuit Judge
Honorable Richard A. Posner, Circuit Judge

No. 91-2265

BOARD OF TRUSTEES OF KNOX COUNTY (INDIANA) HOSPITAL, doing business as GOOD SAMARITAN HOSPITAL,

Plaintiff - Appellant

v.

LOUIS W. SULLIVAN, M.D., Secretary of the Department of Health and Human Services,

Defendant - Appellee

Appeal from the United States District Court for the Southern District of Indiana, Terre Haute Division
No. 90 C 186, Judge Larry J. McKinney

This cause was heard on the record from the above mentioned District Court, and was argued by counsel.

On consideration whereof, **IT IS ORDERED AND ADJUDGED** by this court that the judgment of the District Court is **AFFIRMED**, with costs in accordance with the decision of this court entered this date.
(1061-030690)

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF INDIANA

TERRE HAUTE DIVISION

BOARD OF TRUSTEES OF KNOX COUNTY (INDIANA) HOSPITAL, d/b/a GOOD SAMARITAN HOSPITAL,	)	
Plaintiff,	)	
vs.	)	**CAUSE NO. TH 90-186 C**
LOUIS W. SULLIVAN, M.D., as Secretary of the Department of Health and Human Services,	)	
Defendant.	)	

JUDGMENT

A final judgment is entered for the defendant, and against the plaintiff. Plaintiff takes nothing by way of its complaint. This cause is dismissed with prejudice.

Dated: April 4, 1991.

Larry J. McKinney, Judge
United States District Court
Southern District of Indiana

42 U.S.C. § 1395ww(d)(5)(C)(i) (1984)

The Secretary shall provide for such exceptions and adjustments to the payment amounts established under this subsection as the Secretary deems appropriate to take into account the special needs of regional and national referral centers (including those hospitals of 500 or more beds located in rural areas), and of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under Part A of this subchapter.

49 Fed. Reg. 234, 320, 42 C.F.R. at § 405.476(g) (January 3, 1984)

(g) Referral centers.

(1) Criteria. HCFA will consider a hospital's request for a referral center adjustment to the hospital's prospective payment rates only if the hospital is an acute care hospital that has a provider agreement under Part 489 of this chapter to participate in Medicare as a hospital; and

(i) Is located in a rural area (as defined in § 405.473(b)(6)) and has 500 or more beds available for use; or

(ii) Has an inpatient population such that at least 50 percent of its Medicare patients are referred from other hospitals or from physicians not on the staff of the hospital. In addition, at least 60 percent of the hospital's Medicare patients must live more than 25 miles from the hospital, and at least 60 percent of all the services that the hospital furnishes to Medicare beneficiaries must be furnished to beneficiaries who live more than 25 miles from the hospital.

(2) Payments to rural referral centers with 500 or more beds. A hospital that meets the criteria of paragraph (g)(1)(i) of this section will be paid prospective payments per discharge based on the applicable urban payment rates as determined in accordance with § 405.473(b)(10) or (c)(6), as adjusted by the hospital's area wage index.

Supreme Court, U.S.
FILED
DEC 17 1992
OFFICE OF THE CLERK

No. 92-663

In the Supreme Court of the United States

OCTOBER TERM, 1992

BOARD OF TRUSTEES OF KNOX COUNTY (INDIANA) HOSPITAL, d/b/a GOOD SAMARITAN HOSPITAL, PETITIONER

v.

LOUIS W. SULLIVAN, SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

KENNETH W. STARR
Solicitor General

STUART M. GERSON
Assistant Attorney General

ANTHONY J. STEINMEYER
COLETTE J. WINSTON
Attorneys

Department of Justice
Washington, D.C. 20530
(202) 514-2217

QUESTION PRESENTED

Under 42 U.S.C. 1395ww(d)(5)(C)(i) (Supp. II 1984), the Secretary of Health and Human Services was directed to "provide for such exceptions and adjustments to the [Medicare] payment amounts established under this subsection as the Secretary deems appropriate to take into account the special needs of regional and national referral centers (including those hospitals of 500 or more beds located in rural areas)." The question presented is whether the Secretary's initial regulation under Section 1395ww(d)(5)(C)(i), which has been superseded, properly limited the availability of adjustments to rural referral centers with more than 500 beds.

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In the Supreme Court of the United States

OCTOBER TERM, 1992

No. 92-663

BOARD OF TRUSTEES OF KNOX COUNTY (INDIANA) HOSPITAL, d/b/a GOOD SAMARITAN HOSPITAL, PETITIONER

v.

LOUIS W. SULLIVAN, SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. A1-A11) is reported at 965 F.2d 558. The opinion of the district court (Pet. App. A12-A20) is unpublished.

JURISDICTION

The judgment of the court of appeals (Pet. App. A22) was entered on June 25, 1992. A petition for rehearing was denied on July 14, 1992. Pet. App. A21. The petition for a writ of certiorari was filed on October

13, 1992. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. In the Social Security Amendments of 1983, Pub. L. No. 98-21, § 601(e), 97 Stat. 152-158, Congress established a new system for making payments to providers of inpatient hospital services under the Medicare program. Rather than using reasonable cost or customary charges as the basis for payment, the so-called "prospective payment system" provides for payments based on prospectively determined rates that are applied on a per discharge basis. See generally 42 U.S.C. 1395ww(d); 42 C.F.R. 412.1. The payment rates per discharge depend, in large part, on the diagnosis-related group (DRG) in which a patient's treatment is classified. See 42 U.S.C. 1395ww(d)(1)(A). The Secretary is charged with establishing a classification of DRGs and a methodology for assigning discharges to a given DRG. 42 U.S.C. 1395ww(d)(4)(A). The Secretary also must assign a weighting factor to each DRG, based upon the relative hospital resources used by that group. 42 U.S.C. 1395ww(d)(4)(B); 42 C.F.R. 412.60. For each fiscal year, the Secretary establishes prospective payment rates for discharges classified within a particular DRG. See 42 U.S.C. 1395ww(d)(2)(G) and (3)(D).

In calculating prospective payment rates, the Secretary must calculate not only the weighting factor for a DRG, but also the adjusted average standardized costs by which the weighting factors are multiplied. See 42 U.S.C. 1395ww(d)(2) and (3); 42 C.F.R. 412.62, 412.63. The Secretary's cost calculation begins with a base level of actual allowable costs per discharge for

each hospital. '42 U.S.C. 1395ww(d)(2)(A). After making various adjustments required by the statute, the Secretary calculates for each census region separate average standardized amounts for hospitals in urban and rural areas. 42 U.S.C. 1395ww(d)(2)(D) and (3)(D).

Of specific pertinence here, 42 U.S.C. 1395ww(d)(5)(C)(i) (Supp. II 1984), provided during the relevant period that

> [t]he Secretary shall provide for such exceptions and adjustments to the payment amounts established under this subsection as the Secretary deems appropriate to take into account the special needs of regional and national referral centers (including those hospitals of 500 or more beds located in rural areas) * * * .

During the relevant period, the implementing regulations defined a "referral center" in the following manner:

> [The Health Care Financing Administration] will consider a hospital's request for a referral center adjustment to the hospital's prospective payment rates only if the hospital is an acute care hospital that has a provider agreement under Part 489 of this chapter to participate in Medicare as a hospital; and
>
> (i) Is located in a rural area * * * and has 500 or more beds available for use; or
>
> (ii) Has an inpatient population such that at least 50 percent of its Medicare patients are referred from other hospitals or from physicians not on the staff of the hospital. In addition, at least 60 percent of the hospital's Medicare patients must

> live more than 25 miles from the hospital, and at least 60 percent of all the services that the hospital furnishes to Medicare beneficiaries must be furnished to beneficiaries who live more than 25 miles from the hospital.

49 Fed. Reg. 320 (1984) (adopting 42 C.F.R. 405.476 (g)(1)). Under that provision, only hospitals that qualified as "referral centers" under Section 405.476(g)(1)(i)—that is, hospitals with 500 or more beds—were entitled to the higher payment rates applicable to urban hospitals. 49 Fed. Reg. 320 (1984) (adopting 42 C.F.R. 405.476(g)(2)).[1]

2. Petitioner is a rural hospital that provides services under the Medicare program. In its 1984 cost report, petitioner sought a higher Medicare reimbursement as a rural referral center. Petitioner has 344 beds and was therefore ineligible for treatment as a 500-bed referral center under 42 C.F.R. 405.476(g)(1)(i) (1984). The Secretary's fiscal intermediary denied petitioner's request for higher payments, and the Provider Reimbursement Review Board affirmed. Pet. App. A2.

3. Petitioner then filed this action challenging the Secretary's decision not to provide increased payments to rural "referral centers" with fewer than

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[1] Under the original final regulation, the Secretary did not provide higher reimbursements for any hospitals that qualified as rural "referral centers" pursuant to Section 405.476(g)(1)(ii). The inclusion of that provision was initially designed to gather data to help determine whether a higher rate was warranted for the kind of referral center defined in that subsection. Pet. App. A5; see 49 Fed. Reg. 276 (1984).

500 beds. The district court granted the Secretary's motion for judgment on the pleadings under Fed. R. Civ. P. 12(c). The court determined that the Secretary's definition of "referral center" under 42 C.F.R. 405.476(g)(1)(i) and (ii) (1984) was rational and consistent with the statute. Noting that petitioner did not contend that it satisfied the definition of a "referral center" under Section 405.476(g)(1)(i) or (ii) (1984), the court held that petitioner lacked standing to contest the fact that higher reimbursements were available under subsection (i) but not subsection (ii). Pet. App. A16-A18. In the alternative, the trial court concluded that the Secretary's action was committed to agency discretion and was therefore unreviewable under the Administrative Procedure Act (APA), 5 U.S.C. 701(a)(2). Pet. App. A18-A20.

4. The court of appeals affirmed on other grounds. The court concluded that petitioner had standing to challenge the Secretary's denial of its reimbursement claim under the Medicare statute. Pet. App. A2-A5. The court also found that the Secretary's promulgation of the challenged regulation was not a matter committed to agency discretion within the meaning of the APA. Pet. App. A5-A8. The court held, however, that the regulatory limitation on the availability of higher reimbursement was "reasonable and consistent with the statute." *Id.* at A12.

The court noted that 42 U.S.C. 1395ww(d)(5)(C)(i) (Supp. II 1984) referred to "regional and national referral centers." The court reasoned that this phrase might have been understood to refer only to large facilities typically found in urban centers; hence, in the court's view, the parenthetical phrase—

"including those hospitals of 500 or more beds located in rural areas" (42 U.S.C. 1395ww(d)(5)(C)(i) (Supp. II 1984))—may have been added to ensure that such hospitals, like those in urban areas, were eligible for higher compensation. Pet. App. A10.

In addition, the court observed that the legislative history reflected an expectation that the Secretary would gather information about referral centers in order to assist the formulation of appropriate criteria. Thus, the court held that for 1984—the initial year of the program—the Secretary reasonably limited the higher payments to referral centers having 500 or more beds (the category explicitly mentioned in the statute), while gathering more information on referral centers that met the criteria in subsection (ii) of the regulation. Pet. App. A9-A11.

ARGUMENT

Petitioner renews its contention that the rule applicable to its 1984 cost report was inconsistent with the statute because it made higher reimbursements available only to rural referral centers with 500 or more beds. Pet. 4-11. That claim does not merit further review. The decision of the court of appeals is correct and does not conflict with any decision of this Court or any court of appeals. In addition, the statute and regulation at issue have been amended;[2] thus, the question presented in this case is without continuing importance.[3]

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[2] For cost reporting periods beginning on October 1, 1984, the Secretary revised the relevant regulation to provide for increased availability of adjustments to referral centers and more generous criteria for qualifying as a referral center. 49

The court of appeals correctly concluded that the Secretary's initial approach of limiting higher reimbursement rates to referral centers with 500 or more beds did not offend the statute. The relevant statutory provision directs the Secretary to "provide for such exceptions and adjustments to the payment amounts established under this subsection as the Secretary deems appropriate to take into account the special needs of regional and national referral centers (including those hospitals of 500 or more beds located in rural areas)." 42 U.S.C. 1395ww(d)(5)(C)(i) (Supp. II 1984). As petitioner concedes (Pet. 4), that provision is ambiguous. Thus, even assuming that the matter is not "committed to agency discretion by law" (5 U.S.C. 701(a)(2)),[4] the now-superseded reg-

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Fed. Reg. 34,761-34,763 (1984). As subsequently amended and renumbered, the referral center regulation is now codified at 42 C.F.R. 412.96. The relevant statutory provision has also been amended on several occasions. See, *e.g.*, Spending Reduction Act of 1984, Pub. L. No. 98-369, Tit. III, § 2311(a), 98 Stat. 1076; Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, Tit. IX, § 9302(d)(1), 100 Stat. 1983-1984; Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, Tit. IV, § 4005(d)(1)(a), 101 Stat. 1330-49.

[3] In fact, petitioner has been reclassified as a "referral center" and now receives more generous Medicare payments. The only issue in this case is petitioner's reimbursement for the 1984 cost reporting year. Pet. App. A1 n.1.

[4] We believe that the district court correctly determined (Pet. App. A18-A20) that the issue in this case is committed to agency discretion within the meaning of 5 U.S.C. 701(a)(2). That issue is not what constitutes a "referral center"—a matter as to which there is law to apply. Cf. *Barlow* v. *Collins*, 397 U.S. 159, 166 (1970). Rather, as the district court found (Pet. App. A18), the issue is the Secretary's initial decision not to

ulation that petitioner challenges must be sustained if it is "rational and consistent with the statute." *Sullivan* v. *Everhart*, 494 U.S. 83, 89 (1990).

The court of appeals properly held that the line drawn by the Secretary's January 3, 1984, initial final rule (see 49 Fed. Reg. 320 (1984))—between rural hospitals with 500 or more beds and those with fewer than 500 beds—was rational and consistent with 42 U.S.C. 1395ww(d)(5)(C)(i) (Supp. II 1984). When the

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increase the compensation for any rural "referral center" having fewer than 500 beds. As to that, the relevant statutory provision states that the Secretary shall provide "such exceptions and adjustments to the payment amounts * * * as the Secretary *deems appropriate*." 42 U.S.C. 1395ww(d)(5)(C)(i) (Supp. II 1984) (emphasis added). As this Court said of a similarly phrased statute in *Webster* v. *Doe*, 486 U.S. 592, 600 (1988), "[t]his standard fairly exudes deference * * * and appears * * * to foreclose the application of any meaningful judicial standard of review." The statute in *Webster* allowed the Director of Central Intelligence to terminate an employee whenever he "shall *deem* such termination necessary or advisable in the interests of the United States." 50 U.S.C. 403(c) (emphasis added). This Court reasoned that "[s]hort of permitting cross-examination of the [DCI] concerning his views of the Nation's security and whether the discharged employee was inimical to those interests, we see no basis on which a reviewing court could properly assess an Agency termination decision." 486 U.S. at 600. The same is true here; short of cross-examining Secretary Heckler concerning her views of the appropriateness of temporarily providing adjustments only to rural referral centers with 500 or more beds, there is no meaningful basis for evaluating compliance with 42 U.S.C. 1395ww(d)(5)(C)(i) (Supp. II 1984). As was the case in *Webster*, the statutory language here "strongly suggests that its implementation was 'committed to agency discretion by law.'" 486 U.S. at 600 (quoting 5 U.S.C. 701(a)(2)).

applicable final rule was promulgated, the Secretary reasonably concluded that additional information was needed before determining the appropriate adjustments for rural referral centers with fewer than 500 beds. As the Secretary explained:

> Since there is no generally accepted definition of referral centers, it is not possible at this time to determine which payment adjustments are appropriate. This is because we will not know how referral center costs are atypical when compared to other hospitals until we have an opportunity to examine and analyze in detail the data pertaining to those hospitals (other than large rural hospitals) which apply for referral center status. Only when we have completed an analysis will we be able to determine in what ways referral centers are atypical when compared to other hospitals with respect to their costs, and then to develop an appropriate adjustment.

49 Fed. Reg. 276 (1984).

Accordingly, the initial final rule—which was amended soon after it was promulgated (49 Fed. Reg. 34,761-34,763 (1984))—rationally omitted adjusted payments for any rural referral centers except for those that Congress had explicitly identified for inclusion as "referral centers" under the statute—"those hospitals of 500 or more beds located in rural areas" (42 U.S.C. 1395ww(d)(5)(C)(i) (Supp. II 1984)).[5] Because

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[5] As the court of appeals explained, because 42 U.S.C. 1395ww(d)(5)(C)(i) (Supp. II 1984) was designed to address "the special needs of regional and national referral centers," that provision may be understood to refer generally to "large

the initial final rule was reasonably based upon the lines drawn by the statute itself—and because there is no conflict among the circuits on the construction of 42 U.S.C. 1395ww(d)(5)(C)(i) (Supp. II 1984)—further review is unwarranted.

In any case, the decision below is without continuing importance, because the statute and regulation have both been amended in a manner that clarifies the proper treatment of rural hospitals. Under 42 U.S.C. 1395ww(d)(5)(C)(i) (Supp. II 1990), "regional and national referral centers" are deemed to "includ[e] those hospitals of 275 or more beds located in rural areas." In addition, the amended statute clarifies the factors to be used in classifying rural hospitals as regional referral centers (42 U.S.C. 1395ww(d)(5)(C) (ii) (Supp. II 1990)):

> The Secretary shall provide, under clause (i), for the classification of a rural hospital as a regional referral center if the hospital has a case mix index equal to or greater than the median case mix index for hospitals * * * located in an urban area in the same region * * *, has at least 5,000 discharges a year, or, if less, the median number of

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facilities, ones 'regional' and 'national' in scope." Pet. App. A10. The parenthetical phrase—"including those hospitals of 500 or more beds located in rural areas"—merely made clear that certain large rural hospitals should be treated as "referral centers" under the statute. See *ibid.* Contrary to petitioner's suggestion (Pet. 9-10), it does not follow from the use of the term "including" that Congress also necessarily intended to *require* the Secretary to treat certain other rural hospitals, with fewer than 500 beds, as "referral centers" entitled to higher reimbursements.

> discharges in urban hospitals in the region in which the hospital is located * * * , and meets any other criteria established by the Secretary under clause (i).

The presently effective regulations, moreover, generally provide that the Health Care Financing Administration may adjust prospective payment rates if a hospital acts as a referral center. See 42 C.F.R. 412.90(b). A hospital's status as a referral center, in turn, depends upon (1) the number of beds in a rural hospital (42 C.F.R. 412.96(b)(1)); (2) the percentage of Medicare patients who are referred from other hospitals or who live more than 25 miles from the hospital (42 C.F.R. 412.96(b)(2)); or (3) a rural hospital's ability to meet a combination of criteria relating to case mix, number of discharges, and either medical staff, source of inpatients, or volume of referrals (42 C.F.R. 412.96(c)). For discharges occurring on or after April 1, 1988, rural hospitals that meet any one of those three sets of standards are paid based on applicable urban rates. 42 C.F.R. 412.96(d). Thus, the question presented by petitioner, which concerns a now-superseded regulation that implemented a prior version of the relevant statutory provision, is of no continuing importance.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

KENNETH W. STARR
Solicitor General

STUART M. GERSON
Assistant Attorney General

ANTHONY J. STEINMEYER
COLETTE J. WINSTON
Attorneys

DECEMBER 1992